A matter for debate

Graham Penfold and Dental Tribune discuss recall intervals

Last month dentists were accused of ‘exploiting’ the NHS to maximise their incomes, denying thousands of patients access to treatment, by recalling healthy patients for tests too frequently. Chief Dental Officer (CDO), Barry Cockcroft, told The Times: ‘A few dentists seem to be calling in patients inappropriately. The Primary Care Trust (Primary Care Trust) must sort this out at a local level.’

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Dental Tribune: ‘So Graham where do you stand on this? There are a lot of ‘conspiracy’ theories going around. The Government got a bloody nose over the Health Committee report and is trying to deflect the criticism on to dentists. It’s coming round to Review Body evidence time of year. Or is it just that the figures from the new FPITs happen to be coming in now, showing that dentists are seeing patients too frequently?’

Graham Penfold: ‘I do not really like terms like ‘a few’ or ‘too frequently’; they are far too vague! Exactly, how many is a few? It does not sound like very many and if that’s the case then what is all the fuss about because it cannot be having that much impact? Also, what does too frequently mean? Surely, it is for a dentist to decide in conjunction with the patient how and when they should be seen. Loose language such as this is, in my view, meaningless.

Dental Tribune: ‘But two of the measures collected by the NHS are the percentage of forms for the same patient, re-attending within three months and the percentage returning between three and nine months. The National Institute of Health and Clinical Excellence (NICE) guidance on dental recalls clearly said that many patients with low risk of disease could come back in two years (adults) or one year (children). When the second quarter results came back in September they showed that some dentists were recalling at three month intervals, surely these irregularities should be exposed.’

Graham Penfold: ‘Surely, any ‘irregularities’ should be exposed, but let us look at two key points. What evidence is there to support a three year recall interval for adults or one year for children? I meet with many dentists and I am yet to find one who would support a recall interval of two years for adults; one year is the maximum and that is not suitable for all adults. An awful lot can happen and change in two years. As for children, their teeth can undergo dramatic changes in a short space of time due to a wide variety of factors. For me, under the NHS, all longer recall intervals are really about are freeing up dental capacity to sort out the access issue; it would be interesting to hear the defence societies views on this area! In addition, it has to be said that the deeply flawed new contract has put the need for commercial survival and best patient care in stark conflict with one another, but let’s point the finger of blame for that firmly where it belongs; the senior ‘policy’ makers at DoH.

Dental Tribune: ‘The British Dental Association (BDA) challenged the Government to prove their assertions, surely a risky strategy. Many years ago I used to discuss dento-political matters with a local MP, Ken Weetch (Ipswich). His advice was never to ask a question of the government unless you knew the answer; he was in opposition at the time. If, as seems likely Ministers can prove that some dentists are not following the guidelines then the BDA has egg on its face. Anyway what are they doing admitting that they don’t know? It looks incompetent.’

Graham Penfold: ‘As I have said above, if the guidelines are not really evidence based and aimed instead at getting a government and chief dental officer off the hook on the access issue, then it is little wonder they are not being followed in their entirety. The government could pass a law making it compulsory for people to hop on their left leg for ten minutes every Thursday afternoon, but I doubt whether many citizens would bother to do it! Just as law can only exist with the will of the people, so recall guidelines can only be credible if they are deemed to be in the best interests of both patients and the dentist who is responsible for their care and I do not believe that they are. So, I do not think that the BDA strategy is particularly risky because they are challenging a deeply flawed system underpinned by weak thinking.

Dental Tribune: ‘The PCTs have been given targets for increasing the number of people seen and they pay for the bulk of the care. Surely they can tell the dentists on their patch to see more of the people with problems and fewer of those who just want a reassuring check up. After all the PCT lays down how often you can have tests with your GP. Graham Penfold: ‘I think that PCTs will increasingly contract by postcode so they know all patients in a certain postcode area are covered. It’s a relatively simple process whereby the patients know that piece of information and then the PCT can contract with an appropriate number of practices to provide care against specific criteria. So, if you are in pain or have a dental problem, the contract might say that you will see the patient within 24 hours, but if they just want a routine check up then they might have to wait, say, up to 15 weeks. By this method, PCT’s could claim that the access issue has been resolved satisfactorily.

Dental Tribune: ‘Of course if you are a dentist and don’t like the NICE guidelines, you can always see the patient privately. Or will private practice be governed by NICE?’

Graham Penfold: ‘I believe that the most appropriate recall period is that agreed between the dentist and their patients based on best clinical practice, individual to each patient, and completely free from external influences particularly those which are politically driven. Happily, private practice does not have to face the PCT/NICE drumbeat of ‘you don’t need to see your dentist so often’ and long may that be the case. Long live clinical freedom.

For further information, call Practice Plan on 01691 684135 or visit www.practicplan.co.uk.

About the author

Graham Penfold has a degree in political science and a special interest in primary dental care policy making. He was director of influence and computing with Norfolk family health authority and a partner in the firm of management consultants the Wilcox Penfold partnership who advised both Norwich Union Healthcare and the Royal Bank of Scotland. He was a director of Oasis Healthcare plc for four years and is now operations director with Practice Plan.

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